SELECT JOINT COMMISSION ON MEDICAID OVERSIGHT

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MEETING MINUTES[1]

Meeting Date:	**October 15, 2003**
Meeting Time:	**10:30 A.M.**
Meeting Place:	**State House, 200 W. Washington St., Room 130**
Meeting City:	**Indianapolis, Indiana**
Meeting Number:	**4**

Members Present: **Sen. Patricia Miller, Chairperson; Sen. Connie Lawson; Sen. Rose Antich-Carr; Sen. Vi Simpson; Sen. Sam Smith; Rep. Charlie Brown; Rep. William Crawford; Rep. Clyde Kersey; Rep. David Frizzell; Rep. Mary Kay Budak; Sen. Gary Dillon.**

Members Absent: **Sen. Robert Meeks; Rep. Tim Brown.**

Senator Miller called the meeting to order at 10:40 a.m. Senator Miller told the Commission that Senator R. Meeks requested that the preliminary draft concerning provider reporting be held and that Sen. Meeks would continue to work on the bill draft.

Rick Shaffer, EDS

Mr. Shaffer, representing EDS, distributed a newly formatted EDS Update report on Medicaid claim processing. See Exhibit 1. Mr. Shaffer asked the Commission to comment

[1] Exhibits and other materials referenced in these minutes can be inspected and copied in the Legislative Information Center in Room 230 of the State House in Indianapolis, Indiana. Requests for copies may be mailed to the Legislative Information Center, Legislative Services Agency, 200 West Washington Street, Indianapolis, IN 46204-2789. A fee of $0.15 per page and mailing costs will be charged for copies. These minutes are also available on the Internet at the General Assembly homepage. The URL address of the General Assembly homepage is http://www.ai.org/legislative/. No fee is charged for viewing, downloading, or printing minutes from the Internet.

on the new format and to let him know whether the Commission wanted any additional information included in the report. Pointing out that the report reflected a decrease in the number of recipients and providers participating in the state Medicaid program for state fiscal year 2004, Mr. Shaffer indicated that the figure was misleading and that the difference was that not all recipients had received services, and not all providers had serviced a Medicaid recipient, this early in the state fiscal year.

The Commission requested that future update reports include the dollars paid for the Medicaid program for the same time period the previous year for comparison purposes. A Commission member asked about the length of reimbursement time, and Mr. Shaffer responded that the average EDS claim adjudication time is three days. The Commission member replied that he had received a complaint from a dentist in his district, and Mr. Shaffer stated that he would be interested in learning more information to look into the matter.

Medicaid Fraud

Mr. Alan Pope, representing the Medicaid Fraud Control Unit (MFCU) of the Attorney General's office, stated that the MFCU evenly divides its time among the MFCU's two primary functions: (1) the investigation of Medicaid fraud; and (2) the investigation of Medicaid abuse and neglect. The MFCU has approximately 33 employees, consisting of investigators, auditors, and attorneys. Federal law regulates the MFCU's functions. Specifically, federal law: (1) requires that the MFCU be separate from the state office administering the Medicaid program; and (2) prohibits MFCU from initiating a fraud investigation. Instead, MFCU must rely upon referrals from the Office of Medicaid Policy and Planning (OMPP) and tips from the public that are received on a tip hotline telephone number.

In response to a question from the Commission, Mr. Pope responded that a fraudulent Medicaid paper claim usually looks like a good claim because the person has found a way to beat the system. Often, the person determines how to beat the system by first filing an erroneous claim by mistake. When the person is inaccurately reimbursed because of the mistake, the person has learned of a means to commit the fraud. Mr. Pope further stated that Medicaid fraud is committed more frequently by providers that are not licensed or otherwise regulated by the state. Mr. Pope gave the example of durable medical equipment providers.

The Commission requested statistics from Mr. Pope showing the number of Medicaid fraud cases investigated by the MFCU by county as well as the type of providers who are being found to commit the fraud. In response to a question, Mr. Pope responded that a claim of Medicaid fraud can take years to fully investigate.

Ms. Mary DePrez, Acting Secretary of FSSA, provided information concerning her background and distributed a memorandum from Melanie Bella, Assistant Secretary of OMPP. Ms. DePrez informed the Commission that Ms. Bella regretted missing the meeting but was testifying before Congress in Washington, D.C. concerning Indiana's Chronic Disease Management Program. See Exhibit 2, Ms. Bella's memorandum which was presented by Ms. DePrez.

Ms. Kimberly Forrest, representing Health Care Excel, Mr. Jared Duzan, representing Myers and Stauffer, and Mr. Rick Shaffer, representing EDS, explained each company's role in preventing Medicaid fraud. See Exhibit 3. Mr. Duzan explained that Myers and Stauffer reviews post-claim payments for compliance, recommends system improvements, and uses statistical processes and algorithms to identify issues. Mr. Duzan gave the example of a durable medical equipment provider who was misusing a generic code on the

Medicaid claim form. Myers and Stauffer referred this problem to Health Care Excel for further action.

Ms. Forrest stated that Health Care Excel operates the state's Surveillance Utilization Review. Health Care Excel identifies Medicaid fraud through: (1) a toll free provider concern phone line; (2) algorithms that review surge analysis and specific provider group utilization; (3) an internal review process which looks at claims by specialty to determine the need for onsite audits or investigations; and (4) new provider analysis which compares a new provider's billing practices to those of other providers in the same specialty.

Mr. Shaffer explained that EDS reviews claims on the front end. EDS has over 700 system edits or checks that a claim goes through when the provider first submits the claim. The system checks include determining whether the claim submitted is from a Medicaid provider, whether the claim is for a Medicaid recipient, and whether the service provided is an allowable service.

In response to a question from the Commission concerning whether the claim form was extensive enough, Ms. Forrest responded that the form is sufficient and that a person who is intent upon committing fraud will find a way regardless of the detail in the claim form.

Children's Health Insurance Program (CHIP)

Ms. Elizabeth Culp, CHIP's new director, introduced herself and gave an update on CHIP. See Exhibit 4. Ms. Culp stated that the biggest reason for increases in the number of CHIP recipients is word of mouth.

In response to a question from a Commission member concerning whether CHIP collects information concerning a recipient's body mass index (BMI) and whether recording BMI information would be feasible, Ms. Culp responded that she would find out.

In response to a question concerning how many CHIP recipients have lost CHIP coverage due to a change in the law in 2002 concerning continuous eligibility, Ms. Culp responded that FSSA is still trying to determine this number. Although approximately 30,000 children have lost CHIP coverage since the change in law went into effect, the loss in coverage could be for a variety of reasons, including the recipient moving out of the state, a change in the recipient's family income, and the recipient moving between the Medicaid and CHIP programs. FSSA is still trying to review documents and track document codes to determine this number solely affected by the change in the continuous eligibility change in law. The Commission stated that this statistic is very important and asked Ms. Culp to continue to work on determining the number and report back to the Commission.

Responding to a question concerning whether the CHIP program was having difficulty finding CHIP providers, Ms. Culp responded that the CHIP program is having less difficulty than before in finding dentists to provide services. However, approximately ten counties have provider panels which are full or close to full, meaning that the existing CHIP providers who provide pediatric care may not be accepting new patients. Ms. Culp stated that her office is keeping track of counties that have panels that are 80% or more full and is working with these counties on the problem.

Proposed Legislation Discussion

Preliminary Draft (PD) 3238- This bill draft removes the exemption of risk-based managed care programs from the Medicaid disease management program. PD 3238 allows the State Department of Health to add chronic diseases to the chronic disease registry by administrative rule. Further, public and private third party payors are added as persons to

be used by OMPP in implementing a disease management program and as persons that may report chronic disease cases for the chronic disease registry. See Exhibit 5.

In response to a question by Commission members, Ms. Charlotte MacBeth, MDWise, stated that the risk-based managed care companies' concern is whether the removal of the exemption would result in the duplication of current managed care efforts concerning disease management. The risk-based managed care companies would like to work with OMPP to complement their existing disease management programs.

Mr. Charlie Hiltunen, representing the Indiana Minority Health Coalition, stated that the Coalition is currently working with a managed care program on the program's disease management program. Mr. Hiltunen said that it is necessary to give managed care programs flexibility in designing a disease management program.

After a motion, Sen. Miller requested a roll call vote regarding whether the Commission should recommend passage of PD 3238. The motion to recommend passage of PD 3238 passed by a vote of nine to one. See Exhibit 6.

Senator Miller adjourned the meeting at 12:20 p.m.